FEHB 2004 GUIDE

Guide to Federal Employees Health Benefits Plans

For TCC and former Spouse Enrollees Individuals Eligible To Enroll For:

- Temporary continuation of coverage (TCC)
- Coverage under the spouse equity law or similar statutes providing coverage to former spouses.

Center for
Retirement and
Insurance Services

Visit our web site at www.opm.gov/insure/health

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UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-1000

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

It is hard to believe that a year has passed and the Federal Employees Health Benefits (FEHB) Open Season is here again. This is your annual opportunity to evaluate your personal needs and, if necessary, change health plans. I am pleased to present the 2004 FEHB Guide to help you with your evaluation.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this Guide and our web-based resources make it easier than ever to get information about premiums, to compare benefits, to read customer service satisfaction ratings for the national and local plans that may be of interest, and to learn about quality information from the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and URAC.

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country. President Bush has chosen the FEHB as a model for modernizing and improving Medicare.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become a better educated consumer to meet your healthcare needs. Use this Guide, the health plan brochures, and the web resources at www.opm.gov/insure to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

Sincerely,

Kay Coles James
Director

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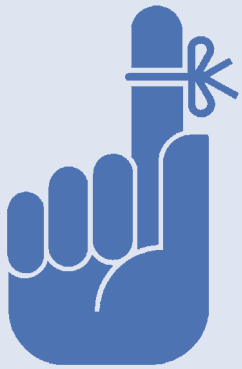
Things to Remember

- ☑ The plan you choose can make a difference in your health.
- ☑ Be aware of benefit changes for 2004.
- ☑ Check the premium for 2004.



The information in this Guide gives you an overview of the FEHB Program and its participating plans. Read the plan brochures before you make any final decisions about health plans.

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Eligibility Requirements

These individuals are eligible to enroll in the FEHB Program but do not receive a Government contribution toward the cost of their enrollment:

Individuals eligible for temporary continuation of coverage (TCC), including:

- former employees whose FEHB coverage ended because they separated from service, including employees who cannot carry FEHB into retirement,
- children who lose FEHB coverage under a family enrollment, and
- former (divorced) spouses who would be eligible for FEHB coverage above except that they have remarried before age 55 or are not entitled to a portion of an employee or annuitant's annuity or survivor benefits based on an employee or annuitant's service.

You may voluntarily cancel your enrollment at any time. However, once your cancellation takes effect, you probably will not be able to enroll again. You will **not** be entitled to a 31-day extension of coverage for conversion to a non-group (private) policy. Family members may enroll only if they are eligible in their own right as Federal employees or annuitants.

Do not cancel your enrollment before reading this section.

TCC enrollees who cancel **cannot** reenroll unless they cancel because they acquire other FEHB coverage, and that coverage ends before the period of temporary continuation of coverage ends.

Former spouses enrolled under the spouse equity law or similar statute who canceled **cannot** reenroll as a former spouse unless they either cancel because they acquire other coverage under the FEHB Program, and that coverage ends, or suspend their FEHB coverage to enroll in a Medicare+Choice health plan under the Social Security Act or because they are eligible under Medicaid or similar State-sponsored program of medical assistance for the needy. (For information about the reenrollment opportunity, contact the Human Resources office or retirement system that handles your account.)

Strict time limits for electing TCC apply. As early as possible before (or after) the event causing the need for TCC happens, contact the employee's Human Resources office or the annuitant's retirement system to get more facts about the requirements for electing coverage.

Former (divorced) spouses eligible to enroll under the spouse equity law or similar statutes. If you are the spouse of a Federal employee or an annuitant and lose FEHB coverage because of divorce, you may elect FEHB coverage — under certain circumstances. Contact the employee's Human Resources office or the annuitant's retirement system for the requirements for electing coverage.

For more information on how to suspend your FEHB enrollment, contact the Human Resources office or retirement system that handles your account.

Time limitations and other restrictions apply. For instance, you must submit documentation that you are suspending FEHB to enroll in a Medicare+Choice health plan or furnish proof of eligibility for coverage under the Medicaid program or similar State-sponsored program of medical assistance for the needy, in case you wish to reenroll in the FEHB Program at a later time.

If you had suspended FEHB coverage for either one of these reasons (and had submitted the required documentation) but now want to enroll in the FEHB Program again, you may enroll during Open Season. You may reenroll outside Open Season only if you move out of the Medicare+Choice health plan's service area, the Medicare+Choice health plan is discontinued, or you involuntarily lose coverage under the Medicaid program or similar State-sponsored program of medical assistance for the needy. If you cancelled your coverage for any other reason, you **cannot** reenroll.

Picking a Health Plan

Step 1: What type of health plan is best for you? You have some basic questions to answer about how you pay for and access medical care. This is because Fee-for-Service (FFS) plans -- with and without a Preferred Provider Organization (PPO) – Health Maintenance Organizations (HMO), Point-of-Service (POS) plans, and Consumer-Driven plans all operate differently.

	Fee-for-Service w/PPO	Fee-for-Service w/o PPO	Health Maintenance Organization	Point-of-Service	Consumer-Driven Plans
Choice of doctors, hospitals, pharmacies, and other providers	You must use the plan's network for full benefits. Not using PPO providers means only some or none of your benefits will be paid.	You may use any doctor, hospital, etc. Benefits are not limited by where you get care.	You generally must use the network; no benefits outside of the network – you pay all costs.	You must use network for full benefits. You may go outside the network but it will cost you more.	You may use network and non-network providers. Not using the network will cost you more.
Specialty care	Referral not required to get full benefits.	Referral not required to get full benefits.	Referral generally required from primary care doctor to get benefits.	Referral required to get full benefits.	Referral not required to get full benefits.
Out-of-pocket costs	You pay fewer costs if you use a PPO provider than if you don't.	You pay regular plan out-of-pocket costs.	Your out-of-pocket costs are generally limited to copayments.	You pay less if you use a network provider than if you don't.	You pay less if you use a network provider than if you don't.
Paperwork	Some if you don't use network providers.	You have to file your own claims.	Little, if any.	Little if you use the network. You will have to file your own claims if you don't use the network.	Some if you don't use network providers.

See Definitions starting on page 8 for a more detailed description of each type of plan.

Picking a Health Plan

Step 2: What services are important to you and what health care do you expect to use? Refer to your medical and insurance records from last year as a guide to what services you might use this year. Add up the actual costs to you, including premiums. Estimate what you might spend on your health care for deductibles, coinsurance/copayments, and services that are not covered. Are there any annual limits for days or services covered and on the dollar amount the plan will spend on you? What is the maximum you will have to pay out-of-pocket each year?

Consult the health plans' brochures to find this benefit information. Copies of brochures as well as a tool to complete this sheet on-line are on our web site at www.opm.gov/insure/health.

	Health Plan _____	**Health Plan _____**	**Health Plan _____**
Annual premium			
Office visit to primary care doctor			
Office visit to specialist			
Hospital inpatient deductible/copay/ coinsurance			
Hospital room & board charges			
Generic drug (local pharmacy)			
Brand name drug (local pharmacy)			
Catastrophic protection limit			
Mental health care visits			
Home health care visits			
Durable medical equipment			
Maternity care			
Well-child care			
Routine physicals			
Accreditation			
The following information can be found in the Member Survey Results section in the benefit charts.			
Overall member satisfaction with plan			
Getting needed care			
Getting care quickly			
How well doctors communicate			
Customer service			
Claims processing			

Picking a Health Plan

Step 3: Consider quality. Quality is how well health plans keep their members healthy or treat them when they are sick. Good quality doesn't always mean receiving more care. Good quality health care means doing the right thing at the right time, in the right way, for the right person to achieve the best possible results. We provide two types of quality information in the plan benefit charts: independent evaluations (accreditation) from private organizations and evaluations by enrollees (member survey).

Accreditation evaluations shown in this Guide are performed by the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and URAC. The following are the accreditation levels used by each organization. The codes correspond to a plan's accreditation level as shown in the plan comparison section.

National Committee for Quality Assurance (www.ncqa.org)	**Excellent** – Levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement AND achieve health plan performance results that are in the highest range of national or regional performance. **Code N1**	**Commendable** – Meets or exceeds NCQA's requirements for consumer protection and quality improvement. **Code N2**	**Accredited** – Meets most of NCQA's requirements for consumer protection and quality improvement. **Code N3**	**Provisional** – Meets some but not all of NCQA's requirements for consumer protection and quality improvement. **Code N4**	**New Health Plan** – Applies to health plans that are less than two years old. **Code N6**
Joint Commission on Accreditation of Healthcare Organizations (www.jcaho.org)	**Accreditation with Full Compliance**- Demonstrates satisfactory compliance with JCAHO standards in all performance areas. **Code J1**	**Accreditation with Requirements for Improvement** – Demonstrates satisfactory compliance with JCAHO standards in most performance areas. **Code J2**	**Provisional** – Demonstrates a previously unaccredited plan's satisfactory compliance with a subset of standards. **Code J3**	**Conditional** – Demonstrates failure to meet standard(s) or specific policy requirement(s) but is believed capable to do so in a specified time period. **Code J4**	
URAC (www.urac.org)	**Full Accreditation** – Demonstrates full compliance with standards. **Code U1**	**Conditional** – Meets most of the standards but needs some improvement before achieving full compliance. **Code U2**	**Provisional** – A plan that has otherwise complied with all standards but has been in operation for less than 6 months. **Code U3**		

Note: *This chart shows the accreditation levels available under each accrediting organization listed. It is not intended to draw comparisons among the different accrediting organizations.*

Member Survey results, shown in the plan comparison sections, are collected, scored, and reported by an independent organization – not by the health plans. Here is a brief explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• Were you satisfied with the choices your health plan gave you to select a personal doctor? • Were you satisfied with the time it takes to get a referral to a specialist?
Getting Care Quickly	• Did you get the advice or help you needed when you called your doctor during regular office hours? • Could you get an appointment for regular or routine care when you wanted?
How Well Doctors Communicate	• Did your doctor listen carefully to you and explain things in a way you could understand? • Did your doctor spend enough time with you?
Customer Service	• Was your plan helpful when you called its customer service department? • Did you have paperwork problems? • Were the plan's written materials understandable?
Claims Processing	• Did your plan pay your claims correctly and in a reasonable time?

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery?
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

FEHB Web Resources

Use the FEHB web site for additional help in choosing the health plan that is right for you.

The FEHB web site at www.opm.gov/insure/health can help you to choose your health plan and enroll. In addition to the information found in this Guide you will find:

- An interactive tool that will allow you to find the health plans that service your area and will allow you to make side-by-side comparisons of the costs, benefits, and quality indicators of the plans that interest you.
- Electronic versions of all health plan brochures.
- An evaluation of how your plan compares to other plans and the FEHB average in important medical areas under the Health Plan Employer Data and Information Set (HEDIS). HEDIS is a set of standardized performance measures that allows users to reliably compare managed care health plan performance across specific clinical areas. The performance measures are related to many significant public health issues such as cancer, heart disease, asthma, and diabetes. Compare plan results at www.opm.gov/insure/health/hedis2002.
- Information on enrolling, with the ability to enroll online for annuitants and employees of selected agencies.
- Information on how plans in the FEHB Program coordinate benefit payments with Medicare.
- A comprehensive set of Frequently Asked Questions and answers on all aspects of the Program.
- An online version of the FEHB Handbook for detailed guidance on FEHB policies and procedures.

Program Features

- **No Waiting Periods.** You can use your benefits as soon as your coverage becomes effective. There are no pre-existing condition limitations even if you change plans.
- **A Choice of Coverage.** Choose between Self Only or Self and Family.
- **A Choice of Plans and Options.** Select from Fee-For-Service (with the option of a Preferred Provider Organization), Health Maintenance Organization, Point of Service plans, or Consumer-Driven plans.
- **Group Benefits.** Under spouse equity coverage, you pay the total monthly premium. Under TCC, you pay the total monthly premium plus a 2 percent administrative charge.
- **Annual Enrollment Opportunity.** Each year you can enroll or change your health plan enrollment. This year the Open Season runs from November 10, 2003, through December 8, 2003.
- **Continued Group Coverage.** Eligibility for you or your family members may continue following your divorce or death. See your Human Resources office for more information.
- **Coverage after FEHB Ends.** You or your family members may be eligible for conversion to non-group (private) coverage when FEHB coverage ends. See your Human Resources office or retirement system for more information.
- **Consumer Protections.** Go to www.opm.gov/insure/health/consumers to see your appeal rights to OPM if you and your plan have a dispute over a claim; to read the Patients' Bill of Rights and the FEHB Program; and to learn about your privacy protections when it comes to your medical information.

FEHB
Federal Employees
Health Benefits Program

Better Information
Better Choices
Better Health

Definitions

Accreditation - The status granted to a health care organization following a rigorous and comprehensive evaluation performed by independent organizations. The evaluation also includes an assessment of the care and service plans are delivering in important areas of public concern such as immunization rates, mammography rates, and member satisfaction.

Brand name drug – A prescription drug that is protected by a patent, supplied by a single company, and marketed under the manufacturer's brand name.

Coinsurance - The amount you pay as your share of the medical services you receive, like for a doctor's visit. Coinsurance is a percentage of the cost of the service (e.g., you pay 20%).

Consumer-Driven plans - Describes a wide range of approaches to give you more incentive to control the cost of either your health benefits or health care. You have greater freedom in spending health care dollars up to a designated amount, and you receive full coverage for in-network preventive care. In return, you assume significantly higher cost sharing expenses after you have used up the designated amount. The catastrophic limit is usually higher than those common in other plans.

Copayment - The amount you pay as your share of the medical services you receive, like for a doctor's visit. A copayment is a fixed dollar amount (e.g., you pay $15).

Fee-For-Service (FFS) - Health coverage in which doctors and other providers receive a fee for each service such as an office visit, test, procedure, or other health care service. The health plan will either pay the medical provider directly or reimburse you for covered services after you have paid the bill and filed an insurance claim. When you need medical attention, you visit the doctor or hospital of your choice.

Formulary – A list of both generic and brand name drugs that are preferred by your health plan. Many prescription drugs produce the same results. Health plans choose formulary drugs that are medically safe and cost effective. A team including pharmacists and physicians meet to review the formulary and make changes as necessary.

Generic drug – A prescription that is not protected by a drug patent. A generic medication is basically a copy of the brand name drug. A generic drug may have a different color or shape than its brand name counterpart, but it must have the same active ingredients, strength, and dosage form (i.e., pill, liquid, or injection), and provide the same effectiveness and safety. Generics generally cost less than brand name drugs.

Definitions

Health Maintenance Organization (HMO) - A health plan that provides care through contracted or employed physicians and hospitals located in particular geographic or service areas. HMOs emphasize prevention and early detection of illness. Your eligibility to enroll in an HMO is determined by where you live or, in some plans, where you work.

In-Network - You receive treatment from the doctors, clinics, health centers, hospitals, medical practices, and other providers with whom your plan has an agreement to care for its members. Examples include a Fee-For-Service plan's PPO or a Health Maintenance Organization. Members have fewer out-of-pocket costs when they use in-network providers.

Out-of-Network - You receive treatment from doctors, hospitals, and medical practitioners other than those with whom the plan has an agreement, and pay more to do so. Members in a PPO-only option who receive services outside the PPO network generally pay all charges.

Point of Service (POS) - A product offered by a health plan that has both in-network and out-of-network features. In a POS you don't have to use the plan's network of providers for every service but you generally pay more out of network.

Preferred Provider Organization (PPO) - The PPO is similar to FFS insurance except it uses a network of providers. PPOs give you the choice of using doctors and other providers in the network or using non-network providers. You don't have to use the PPO, but there are advantages if you do. (Be aware, however, that some of the services provided in a PPO hospital may not be covered by PPO arrangements. Room and board will be covered, but anesthesia and radiology, for instance, may be covered under non-PPO benefits.) Note that some FFS plans may offer an enrollment option that is "PPO-only." You **must** use network providers to receive benefits from a PPO-only plan.

Provider - A doctor, hospital, health care practitioner, pharmacy, or health care facility.

The Federal Flexible Spending Account Program

OPM wants to be sure you know about two new Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program,** also known as **FSAFeds**, lets you set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20 to more than 40 percent on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** covers long term care costs not covered under the FEHB Program.

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by the FSAFeds Program:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by your FEHB Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. ***Note***: The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is $3,000 annually. The minimum amount is $250 annually.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is $5,000 annually. The minimum amount is $250 annually. **Note**: The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is $5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is $2,500 per year. The limit includes any child care subsidy you may receive

Enroll during Open Season

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy.

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at **www.fsafeds.com**.
- Call the toll –free number 1-877-FSAFeds (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and an FSAFeds Benefit Counselor will help you enroll.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFeds Program. SHPS is the largest FSA administrator in the nation and will be responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFeds.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you're not enrolled in FEHB – you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible

The Federal Flexible Spending Account Program

for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.
NOTE: FSAFeds is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the "use-it-or-lose-it" rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFeds when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFeds during this Open Season.

The **FSAFeds Calculator** at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

What can my HCFSA pay for?

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at http://www.irs.gov/pub/irs-pdf/p502.pdf. If you do not see your service or expense listed in Publication 502, please call an FSAFeds Benefit Counselor at 1-877-FSAFeds (372-3337), who will be able to answer your specific questions.

Tax savings with an FSA

An FSA lets you allot money for eligible expenses ***before*** your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will also be lower. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	$50,000	$50,000
And you deposit this amount into an FSA:	$ 2,000	-$0-
Your taxable income is now:	$48,000	$50,000
Subtract Federal & Social Security taxes:	$13,807	$14,383
If you spend after-tax dollars for expenses:	-$0-	$ 2,000
Your real spendable income is:	$34,193	$33,617
Your tax savings:	$576	-$0-

The Federal Flexible Spending Account Program

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon in which retirement system you are enrolled (CSRS or FERS), as well as your individual tax situation. In this example, the individual received $2,000 in services for $1,424, a discount of almost 36%. You may also wish to consult a tax professional for more information on the tax implications of an FSA.

Tax Credits and Deductions

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFeds.

Health Care Expenses

The HCFSA is tax-free from the first dollar. In addition, you may be reimbursed from the HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example listed in the above chart, only health care expenses exceeding $3,750 (7.5% of $50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exception is not available on your Federal income tax return.

Dependent Care Expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

Does it cost me anything to participate in FSAFeds?

Probably not. While there is an administrative fee of $4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFeds.com web site or call 1-877-FSAFeds (372-3337). Also, remember that participating in FSAFeds can cost you money if you don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

Contact us

To find out more or to enroll, please visit the **FSAFeds web site** at **www.fsafeds.com**, or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFeds (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.

- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent so you won't have to worry about being a burden to your loved ones.

- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply the lower your premiums.

- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Stop Health Care Fraud

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium. OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your health plan identification number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid health care providers who say that an item or service is not usually covered, but they know how to bill your health plan to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from your health plan.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get your health plan to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call your health plan and explain the situation.
    - If they do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Remember, FEHB covered family members may not include:
    - your former spouse after a divorce decree or annulment is final (even if a court orders it); or
    - your child over age 22 unless he/she became incapable of self support before age 22.
- If you have any questions about the eligibility of a dependent, check with your Human Resources office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Plan Comparisons

Nationwide Fee-For-Service Plans Open to All

(Pages 16 through 19)

Fee-For-Service (FFS) Plans with a Preferred Provider Organization (PPO) — An FFS plan that allows you to see medical providers who reduce their charges to the plan; you pay less money out-of-pocket when you use a PPO provider. When you visit a PPO you usually won't have to file claims or paperwork. However, going to a PPO hospital does not guarantee PPO benefits for all services received within that hospital. For instance, lab work and radiology services from independent practitioners within the hospital are frequently not covered by the PPO agreement.

Fee-For-Service (FFS) Plans (non-PPO) — An FFS plan that either pays the medical provider directly or reimburses you for covered medical expenses. When you need medical attention, you visit the doctor or hospital of your choice.

In **PPO-only** options, you must use PPO providers to receive benefits.

Consumer-Driven Plans — Describes a wide range of approaches to give you more incentive to control the cost of either your health benefits or health care. You have greater freedom in spending health care dollars up to a designated amount, and you receive full coverage for in-network preventive care. In return, you assume significantly higher cost sharing expenses after you have used up the designated amount. The catastrophic limit is usually higher than those common in other plans.

Nationwide Fee-for-Service Plans Open to All

How to read this chart:

The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision*. The chart does not show all of your possible out-of-pocket costs.

The **Deductibles** shown are the amount of covered expenses that you pay before your health plan begins to pay.

Calendar Year deductibles for families are two or more times the per person amount shown.

In some plans your combined **Prescription Drug** purchases from Mail Order and local pharmacies count toward the deductible. In other plans, only purchases from local pharmacies count. Some plans require each family member to meet a per person deductible.

The **Hospital Inpatient** deductible is what you pay each time you are admitted to a hospital.

Doctors shows what you pay for inpatient surgical services and for office visits.

Your share of **Hospital Inpatient Room and Board** covered charges is shown.

The **Generic** drug figure is the copayment or coinsurance most commonly paid by members of this health plan for a Generic formulary drug.

Plan name	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
APWU Health Plan-High (APWU)	800/222-2798	471	472	386.36	847.90	394.09	864.86
APWU Health Plan-Consumer driven (APWU)	800/222-2798	474	475	337.55	786.05	344.30	801.77
Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS)	Local phone #	104	105	368.98	844.94	376.36	861.84
Blue Cross and Blue Shield Service Benefit Plan-Basic (BCBS)	Local phone #	111	112	329.29	771.29	335.88	786.72
GEHA Benefit Plan-High (GEHA)	800/821-6136	311	312	428.22	931.97	436.78	950.61
GEHA Benefit Plan-Std (GEHA)	800/821-6136	314	315	262.17	595.83	267.41	607.75
Mail Handlers-High (MH)	800/410-7778	451	452	470.15	991.68	479.55	1011.51
Mail Handlers-Std (MH)	800/410-7778	454	455	278.72	605.04	284.29	617.14
NALC	888/636-6252	321	322	375.01	801.39	382.51	817.42
PBP Health Plan-High (PBP)	800-544-7111	361	362	659.66	1423.22	672.85	1451.68
PBP Health Plan-Std (PBP)	800-544-7111	364	365	410.15	929.05	418.35	947.63

Brand Name/Non-formulary is what you pay for a manufacturer's Brand name drug on this health plan's formulary. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in this column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a Non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

The prescription drug copayments or coinsurances described in this chart do not represent the complete range of cost-sharing under these plans. Many plans have variations in their prescription drug benefits (e.g., you pay the greater of a dollar amount or a percentage, or you pay one amount for your first prescription and then a different amount for refills). The prescription drug figures in this chart show what most plan members pay for their medications under each plan. **You must read the plan brochure for a complete description of prescription drug and all other benefits.**

Plan	Benefit Type	Medical-Surgical – You Pay								
		Deductible			Copay ($)/Coinsurance (%)					
		Per Person		Hospital Inpatient	Doctors		Hospital Inpatient	Prescription Drugs		
		Calendar Year	Prescription Drug		Office Visits	Inpatient Surgical Services	R&B	Generic	Brand Name / Non-formulary	Mail Order Discounts
APWU-High	PPO Non-PPO	$275 $500	None None	None $300	$18 30%	10% 30%	10% 30%	$8 50%	25% 50%	Yes No
APWU	PPO Non-PPO	$600* $600*	None None	None None	15% 40%	15% 40%	15% 40%	25% N/A	25%/25% N/A	No No
BCBS -Std	PPO Non-PPO	$250 $250	None None	$100 $300	$15 25%	10% 25%	Nothing 30%	25% 45%+	25% 45%+	Yes No
BCBS -Basic	PPO	None	None	$100/day x 5	$20/$30	$100	Nothing	$10	$25/$35 or 50%	No
GEHA -High	PPO Non-PPO	$350 $350	None None	$100 $300	$20 25%	10% 25%	Nothing Nothing	$5 $5	$25 $25	Yes Yes
GEHA -Std	PPO Non-PPO	$450 $450	None None	None None	$10 35%	15% 35%	15% 35%	$5 $5	50% 50%	Yes Yes
MH -High	PPO Non-PPO	$250 $300	$200 $200	$100 $300	$20/$10 30%	10% 30%	Nothing 30%	$10 50%	$25/$40 50%	Yes Yes
MH -Std	PPO Non-PPO	$300 $350	$400 $400	$200 $400	$20/$10 30%	10% 30%	Nothing 30%	$10 50%	$30/$45 50%	Yes Yes
NALC	PPO Non-PPO	$250 $300	None $25	None $100	$20 30%	10% 30%	10% 30%	25% 50%	25% 50%+	Yes Yes
PBP -High	PPO Non-PPO	$200 $500	$90 $90	None $150	10% 20%	10% 25%	10% 25%	$3 20%+	$25 or 20%/$40 or 20% 20%+	Yes Yes
PBP -Std	PPO Non-PPO	$250 $600	$90 $90	None $250	$8 30%	9% 30%	9% 30%	$4 30%+	$30 or 20%/$40 or 20% 30%+	Yes Yes

** Rollover from previous year may reduce your deductible.*

Nationwide Fee-for-Service Plans Open to All

Member Survey results are collected, scored, and reported by an independent organization – not by the health plans. Here is a brief explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• Were you satisfied with the choices your health plan gave you to select a personal doctor? • Were you satisfied with the time it takes to get a referral to a specialist?
Getting Care Quickly	• Did you get the advice or help you needed when you called your doctor during regular office hours? • Could you get an appointment for regular or routine care when you wanted?
How Well Doctors Communicate	• Did your doctor listen carefully to you and explain things in a way you could understand? • Did your doctor spend enough time with you?
Customer Service	• Was your plan helpful when you called its customer service department? • Did you have paperwork problems? • Were the plan's written materials understandable?
Claims Processing	• Did your plan pay your claims correctly and in a reasonable time?

Member Survey Results
● above average, ◒ average, ○ below average

Plan Name	Plan Code	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
APWU Health Plan-High	47	●	◒	●	●	●	●
APWU Health Plan-Consumer driven	47	●	◒	●	●	●	●
Blue Cross and Blue Shield Service Benefit Plan-Std	10	◒	◒	◒	◒	○	◒
Blue Cross and Blue Shield Service Benefit Plan-Basic	11	○	○	○	○	○	○
GEHA Benefit Plan-High	31	●	◒	◒	◒	●	●
GEHA Benefit Plan-Std	31	●	◒	◒	◒	●	●
Mail Handlers-High	45	○	◒	○	◒	◒	◒
Mail Handlers-Std	45	○	◒	○	◒	◒	◒
NALC	32	●	●	●	●	●	●
PBP Health Plan-High	36	◒	◒	●	●	○	○
PBP Health Plan-Std	36	◒	◒	●	●	○	○

Fee-For-Service Plans – Blue Cross and Blue Shield Service Benefit Plan – Member Survey Results for Select States

This year we are providing more detailed information regarding the quality of services provided by our health plans. We are including the results of the Member Satisfaction survey at the *state level* for eight local Blue Cross Blue Shield (BCBS) Plans. In the past, BCBS has conducted a single survey representing all of its members *nation-wide*. This year, however, we are able to provide local member satisfaction results for both the Standard Option plan and the Basic Option plan.

In the future, we expect to increase the number of plans conducting local or regional Member Satisfaction surveys. We look forward to making those results available to help you select quality health plans.

Below are Member Survey ratings for local BCBS plans by location:

Plan Name	Location	Plan Code	Member Survey Results ● above average, ◒ average, ○ below average					
			Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Blue Cross and Blue Shield Service Benefit Plan - Standard	Arizona	10	○	○	○	○	◒	●
Blue Cross and Blue Shield Service Benefit Plan - Basic	Arizona	11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan - Standard	California	10	●	○	◒	◒	◒	●
Blue Cross and Blue Shield Service Benefit Plan - Basic	California	11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan - Standard	District of Columbia	10	◒	◒	○	◒	◒	◒
Blue Cross and Blue Shield Service Benefit Plan - Basic	District of Columbia	11	○	○	○	○	○	◒
Blue Cross and Blue Shield Service Benefit Plan - Standard	Florida	10	●	◒	○	○	◒	●
Blue Cross and Blue Shield Service Benefit Plan - Basic	Florida	11	○	○	○	○	○	◒
Blue Cross and Blue Shield Service Benefit Plan - Standard	Illinois	10	◒	●	◒	◒	◒	◒
Blue Cross and Blue Shield Service Benefit Plan - Basic	Illinois	11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan - Standard	Maryland	10	◒	◒	◒	◒	○	◒
Blue Cross and Blue Shield Service Benefit Plan - Basic	Maryland	11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan - Standard	Texas	10	●	◒	◒	●	◒	◒
Blue Cross and Blue Shield Service Benefit Plan - Basic	Texas	11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan - Standard	Virginia	10	●	◒	◒	◒	●	●
Blue Cross and Blue Shield Service Benefit Plan - Basic	Virginia	11	○	○	○	○	◒	●

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Plan Comparisons

Nationwide Fee-For-Service Plans Open Only to Specific Groups

(Pages 22 through 24)

Fee-For-Service (FFS) Plans with a Preferred Provider Organization (PPO) — An FFS plan that allows you to see medical providers who reduce their charges to the plan; you pay less money out-of-pocket when you use a PPO provider. When you visit a PPO you usually won't have to file claims or paperwork. However, going to a PPO hospital does not guarantee PPO benefits for all services received within that hospital. For instance, lab work and radiology services from independent practitioners within the hospital are frequently not covered by the PPO agreement.

Fee-For-Service (FFS) Plans (non-PPO) — An FFS plan that either pays the medical provider directly or reimburses you for covered medical expenses. When you need medical attention, you visit the doctor or hospital of your choice.

Nationwide Fee-for-Service Plans Open Only to Specific Groups

How to read this chart:

The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision*. The chart does not show all of your possible out-of-pocket costs.

The **Deductibles** shown are the amount of covered expenses that you pay before your health plan begins to pay.

Calendar Year deductibles for families are two or more times the per person amount shown.

In some plans your combined **Prescription Drug** purchases from Mail Order and local pharmacies count toward the deductible. In other plans, only purchases from local pharmacies count. Some plans require each family member to meet a per person deductible.

The **Hospital Inpatient** deductible is what you pay each time you are admitted to a hospital.

Doctors shows what you pay for inpatient surgical services and for office visits.

Your share of **Hospital Inpatient Room and Board** covered charges is shown.

The **Generic** drug figure is the copayment or coinsurance most commonly paid by members of this health plan for a Generic formulary drug.

Plan Name	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Association Benefit Plan (ABP)	800/634-0069	421	422	390.35	899.19	398.16	917.17
Foreign Service Benefit Plan (FS)	202/833-4910	401	402	352.47	853.67	359.52	870.74
Panama Canal Area Benefit Plan (PCA)	800/548-8969	431	432	329.79	688.39	336.39	702.16
Rural Carrier Benefit Plan (Rural)	800/638-8432	381	382	433.20	881.44	441.86	899.07
SAMBA	800/638-6589	441	442	416.24	980.24	424.56	999.84
Secret Service Employees Health Association (SSEHA)	800/296-0724	Y71	Y72	380.77	902.42	388.39	920.47

Brand Name/Non-formulary is what you pay for a manufacturer's Brand name drug on this health plan's formulary. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in this column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a Non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

The prescription drug copayments or coinsurances described in this chart do not represent the complete range of cost-sharing under these plans. Many plans have variations in their prescription drug benefits (e.g., you pay the greater of a dollar amount or a percentage, or you pay one amount for your first prescription and then a different amount for refills). The prescription drug figures in this chart show what most plan members pay for their medications under each plan. **You must read the plan brochure for a complete description of prescription drug and all other benefits.**

Plan	Benefit Type	Medical-Surgical – You Pay								
		Deductible			Copay ($)/Coinsurance (%)					
		Per Person		Hospital Inpatient	Doctors		Hospital Inpatient	Prescription drugs		
		Calendar Year	Prescription Drug		Office Visits	Inpatient Surgical Services	R&B	Generic	Brand Name / Non-formulary	Mail Order Discounts
ABP	PPO Non-PPO	$300 $300	None None	$100 $300	$10 30%	10% 30%	Nothing 30%	$5 $5	$25/$40 $25/$40	Yes Yes
FS	PPO Non-PPO	$300 $300	None None	Nothing $200	10% 30%	10% 30%	Nothing 20%	$10/25% $10/25%	$20/25%/N/A $20/25%/N/A	Yes Yes
PCA	POS FFS	None None	$400 $400	$50 $125	$10 50%	Nothing 50%	Nothing 50%	50% 50%	50% 50%	No No
Rural	PPO Non-PPO	$350 $400	$200 $200	$100 $300	$20 25%	10% 20%	Nothing 20%	30% 30%	30% 30%	Yes Yes
SAMBA	PPO Non-PPO	$350 $350	None None	$200 $300	$20 30%	10% 30%	Nothing 30%	$10 $10	$25/$40 $25/$40	Yes Yes
SSEHA	Par Non-Par	$200 $200	None None	$100 $100+any diff.	20% 20%+diff.	20% 20%+diff.	Nothing 20%+diff.	$10 All chgs.	$20 All chgs	Yes No

*The Panama Canal Area Plan provides a point-of-service product within the Republic of Panama.

Nationwide Fee-for-Service Plans Open Only to Specific Groups

Member Survey results are collected, scored, and reported by an independent organization – not by the health plans. Here is a brief explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• Were you satisfied with the choices your health plan gave you to select a personal doctor? • Were you satisfied with the time it takes to get a referral to a specialist?
Getting Care Quickly	• Did you get the advice or help you needed when you called your doctor during regular office hours? • Could you get an appointment for regular or routine care when you wanted?
How Well Doctors Communicate	• Did your doctor listen carefully to you and explain things in a way you could understand? • Did your doctor spend enough time with you?
Customer Service	• Was your plan helpful when you called its customer service department? • Did you have paperwork problems? • Were the plan's written materials understandable?
Claims Processing	• Did your plan pay your claims correctly and in a reasonable time?

		Member Survey Results ● above average, ◒ average, ○ below average					
Plan Name	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Association Benefit Plan	42	●	◒	●	◒	●	●
Foreign Service Benefit Plan	40	◒	○	○	○	○	○
Panama Canal Area Benefit Plan	43	○	●	◒	●	●	○
Rural Carrier Benefit Plan	38	●	●	●	◒	●	●
SAMBA	44	●	○	◒	◒	◒	●
Secret Service Employees Health Association	Y7	○	◒	○	○	○	○

Plan Comparisons

Health Maintenance Organization Plans, Plans Offering a Point of Service Product, and Local Consumer-Driven Plans

(Pages 26 through 53)

Health Maintenance Organization (HMO) — A health plan that provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service you receive and free you from completing paperwork or being billed for covered services. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work. Some HMOs are affiliated with or have arrangements with HMOs in other service areas for non-emergency care if you travel or are away from home for extended periods. Plans that offer reciprocity discuss it in their brochure.

- The HMO provides a comprehensive set of services — as long as you use the doctors and hospitals affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and generally no coinsurance for inhospital care.
- Most HMOs ask you to choose a doctor or medical group to be your primary care physician (PCP). Your PCP provides your general medical care. In many HMOs, you must get authorization or a "referral" from your PCP to see other providers. The referral is a recommendation by your physician for you to be evaluated and/or treated by a different physician or medical professional. The referral ensures that you see the right provider for the care most appropriate to your condition.
- Care is not covered from a provider not in the plan's network unless it's emergency care or your plan has an arrangement with another plan.

Plans Offering a Point of Service (POS) Product — A product similar to an HMO and FFS plan.

The POS product lets you use providers who are not part of the HMO network for some services. However, you pay more for using these non-network providers. You usually pay higher deductibles and coinsurances than you pay with a plan provider. You will also need to file a claim for reimbursement, like in an FFS plan. The HMO plan wants you to use its network of providers, but recognizes that sometimes enrollees want to choose their own provider.

The POS plans have two rows for "In Network" and "Out of Network" benefits. In Network shows what you pay if you go to the plan's providers; Out of Network shows what you pay if you decide not to go to the plan's providers.

Consumer-Driven Plans — Describes a wide range of approaches to give you more incentive to control the cost of either your health benefits or health care. You have greater freedom in spending health care dollars up to a designated amount, and you receive full coverage for in-network preventive care. In return, you assume significantly higher cost sharing expenses after you have used up the designated amount. The catastrophic limit is usually higher than those common in other plans.

Health Maintenance Organization (HMO) and Point of Service (POS) Plans

How to read this chart: The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Alabama								
HealthSpring of Alabama, Inc. - Birmingham/Other areas	800/947-5093	DF1	DF2	374.12	957.73	381.60	976.88	
Arizona								
Aetna Health Inc. - Phoenix/Tucson Areas	800/537-9384	WQ1	WQ2	250.23	687.33	255.23	701.08	NCQA 2
Health Net of Arizona, Inc. - Maricopa/Pima/Other AZ counties	800/289-2818	A71	A72	306.87	777.51	313.01	793.06	NCQA 2
Humana CoverageFirst (Consumer Driven Plan) - Phoenix	888/393-6765	DB1	DB2	197.75	454.81	201.71	463.91	
PacifiCare Desert Region (AZ) - Maricopa, Pima County & Apache Junction	800-531-3341	A31	A32	278.16	692.64	283.72	706.49	NCQA 1
California								
Aetna Health Inc. - Los Angeles and San Diego Areas	800/537-9384	2X1	2X2	234.59	571.98	239.28	583.42	NCQA 2
Aetna HealthFund (Consumer Driven Plan) - Northern/Central Valley/Southern CA	888/238-6240	221	222	280.45	645.08	286.06	657.98	
Blue Cross - HMO - Most of California	800/235-8631	M51	M52	334.79	825.76	341.49	842.28	NCQA 1
Blue Shield of CA Access+ - Most of California	800/880-8086	SJ1	SJ2	292.22	724.86	298.06	739.36	NCQA 1
Health Net of California - Most of California	800/522-0088	LB1	LB2	309.73	733.20	315.92	747.86	NCQA 1
Kaiser Permanente - Northern California	800/464-4000	591	592	342.27	816.99	349.12	833.33	NCQA 1
Kaiser Permanente - Southern California	800/464-4000	621	622	321.12	742.17	327.54	757.01	NCQA 1
PacifiCare of California - Most of California	800-531-3341	CY1	CY2	259.89	602.96	265.09	615.02	NCQA 1
UHP Healthcare - LA/Orange/San Bernardino Counties	800/544-0088	C41	C42	233.29	496.77	237.96	506.71	JCAHO 1
Universal Care - Southern California	800/635-6668	6Q1	6Q2	238.64	629.94	243.41	642.54	NCQA 2
Colorado								
Kaiser Permanente - Denver/Colorado Springs areas	800/632-9700	651	652	309.88	799.50	316.08	815.49	NCQA 1
PacifiCare of Colorado - Denver/Colorado Springs/Ft.Collins	800/877-9777	D61	D62	337.98	807.80	344.74	823.96	NCQA 1
Connecticut								
Aetna HealthFund (Consumer Driven Plan) - All of Connecticut	888/238-6240	221	222	280.45	645.08	286.06	657.98	
ConnectiCare - All of Connecticut	800/251-7722	TE1	TE2	330.11	864.54	336.71	881.83	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 4 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 4 for details. A lower number means a better accreditation.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs: Generic	Prescription Drugs: Brand name/ Non-formulary	Prescription Drugs: Mail order discount	Member Survey Results: Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Alabama											
HealthSpring of Alabama, Inc.	$20/$25	$100/day x 5	$10	$25/$50	Yes	●	●	●	●	◒	◒
Arizona											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	○	○	○	○	○	○
Health Net of Arizona, Inc.	$15/$15	$100/day x 5	$10	$30/$45	Yes	○	○	○	○	◒	
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
PacifiCare Desert Region (AZ & NV)	$15/$30	$200/ day x 5	$15	$35/$50	Yes	◒	○	◒	◒	◒	●
California											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	○	○	○	◒	◒
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
Blue Cross- HMO	$10/$10	None	$5	$10/50%	Yes	◒	○	○	◒	◒	◒
Blue Shield of CA Access+	$10/$10	None	$5	$10/$25	Yes	◒	○	◒	◒	◒	◒
Health Net of California	$10/$10	$100	$10	$20/$35	Yes	◒	○	○	◒	○	◒
Kaiser Permanente	$15/$15	None	$10	$25	No	●	○	○	○	◒	●
Kaiser Permanente	$10/$10	None	$10	$25	No	●	○	○	○	●	◒
PacifiCare of California	$15/$30	$100/day x 3	$15	$35/$50	Yes	●	◒	◒	◒	◒	◒
UHP Healthcare	$10/$10	$300	$10	$30/$50	No						
Universal Care	$10/$10	$300	$10	$20/$30	Yes	◒	○	○	◒	◒	◒
Colorado											
Kaiser Permanente	$15/$25	$250	$10	$20	No	◒	◒	◒	○	◒	◒
PacifiCare of Colorado	$10/$40	$150/day x 5	$10	$35/$50	Yes	○	◒	●	◒	○	◒
Connecticut											
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
ConnectiCare	$10/$10	None	$10	$20/$35	Yes	●	●	●	●	●	●

** See Brochure for details on patient's payment responsibility.*

Health Maintenance Organization (HMO) and Point of Service (POS) Plans

How to read this chart: The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
District of Columbia								
Aetna Health Inc.-High -Washington, DC Area	800/537-9384	JN1	JN2	348.75	785.44	355.73	801.15	NCQA 1
Aetna Health Inc.-Std - Washington, DC Area	800/537-9384	JN4	JN5	229.13	536.19	233.71	546.91	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - All of Washington D.C.	888/238-6240	221	222	280.45	645.08	286.06	657.98	
CareFirst BlueChoice - Washington, D.C. Metro Area	866/520-6099	2G1	2G2	393.55	885.37	401.42	903.08	NCQA 2
Kaiser Permanente - Washington, DC area	301/468-6000	E31	E32	316.29	752.81	322.62	767.87	NCQA 2
M.D. IPA - Washington, DC area	800/251-0956	JP1	JP2	318.09	763.47	324.45	778.74	NCQA 1
Florida								
Av-Med Health Plan - Broward, Dade and Palm Beach	800/882-8633	ML1	ML2	318.11	874.64	324.47	892.13	NCQA 2
Capital Health Plan - Tallahassee area	850/383-3311	EA1	EA2	321.79	852.82	328.23	869.88	NCQA 1
Humana CoverageFirst (Consumer Driven Plan) - Tampa	888/393-6765	MJ1	MJ2	218.57	502.69	222.94	512.74	
Humana CoverageFirst (Consumer Driven Plan) - Jacksonville	888/393-6765	MQ1	MQ2	228.97	526.63	233.55	537.16	
Humana CoverageFirst (Consumer Driven Plan) - South Florida	888/393-6765	QP1	QP2	208.17	478.77	212.33	488.35	
Humana Medical Plan - South Florida	888/393-6765	EE1	EE2	326.28	750.49	332.81	765.50	URAC 1
JMH Health Plan - Broward-Dade counties	800/721-2993	J81	J82	287.43	711.30	293.18	725.53	
Total Health Choice - Broward/Dade/Palm Beach Counties	800/213-1133	4A1	4A2	253.05	630.50	258.11	643.11	
Vista Healthplan - South Florida	866/847-8235	3N1	3N2	351.63	966.72	358.66	986.05	
Vista Healthplan - Pensacola area	866/847-8235	RK1	RK2	343.74	917.82	350.61	936.18	
Vista Healthplan - Gainesville	866/847-8235	UL1	UL2	273.98	731.53	279.46	746.16	
Vista Healthplan - Tallahassee	866/847-8235	Y91	Y92	258.16	689.35	263.32	703.14	
Vista Healthplan of South Florida - Southern Florida	800/441-5501	5E1	5E2	243.77	670.39	248.65	683.80	
Georgia								
Aetna Health Inc. - Atlanta and Athens Areas	800/537-9384	2U1	2U2	289.49	698.34	295.28	712.31	NCQA 2
Aetna HealthFund (Consumer Driven Plan) - Atlanta Area	888/238-6240	221	222	280.45	645.08	286.06	657.98	
Kaiser Permanente - Atlanta area	800/611-1811	F81	F82	278.48	707.01	284.05	721.15	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 4 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 4 for details. A lower number means a better accreditation.

Member Survey Results: ● above average, ◒ average, ○ below average

Plan Name		Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs: Generic	Prescription Drugs: Brand name/ Non-formulary	Prescription Drugs: Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
District of Columbia												
Aetna Health Inc.-High		$15/$20	$150/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna Health Inc.-Std		$20/$25	$250/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna HealthFund	- In-Network - Out-of-Network	15%*/15%* 40%*/40%*	15%* 40%*	$10* $10*	$25*/$40* $25*/$40*	Yes* Yes*						
CareFirst BlueChoice		$20/$30	$100/day x 5	$10	$25/$40	Yes	○	○	○	◒	○	○
Kaiser Permanente		$10/$20	$100	$10/$20Net	$20/$40	Yes	◒	○	○	○	◒	◒
M.D. IPA		$10/$20	$100	$8	$20/$35	No	◒	◒	◒	◒	●	●
Florida												
Av-Med Health Plan		$15/$25	$100/dayx5	$15	$30/$50	No	◒	○	○	○	◒	◒
Capital Health Plan		$10/$10	$100	$8	$25/$40	No	●	●	◒	◒	●	●
Humana CoverageFirst	- In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana CoverageFirst	- In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana CoverageFirst	- In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana Medical Plan		$10/$20	$100/day x 3	$5/$20	$20/$40	No	○	○	○	○	◒	○
JMH Health Plan		$10/$10	None	$5	50%	No						
Total Health Choice		$10/$10	$100	$5	$15	No						
Vista Healthplan		$10/$20	$100/day x 3	$10	$20/$40	Yes	○	○	○	○	○	○
Vista Healthplan		$10/$20	$100/day x 3	$10	$20/$40	Yes						
Vista Healthplan		$10/$20	$100/day x 3	$10	$20/$40	Yes						
Vista Healthplan		$10/$20	$100/day x 3	$10	$20/$40	Yes						
Vista Healthplan of South Florida		$10/$20	$100 x 3 days	$10	$20/$40	Yes	○	○	○	○	○	○
Georgia												
Aetna Health Inc.		$20/$25	$250/day x 3	$10	$25/$40	Yes	○	◒	○	○	◒	○
Aetna HealthFund	- In-Network - Out-of-Network	15%*/15%* 40%*/40%*	15%* 40%*	$10* $10*	$25*/$40* $25*/$40*	Yes* Yes*						
Kaiser Permanente		$15/$15	$250	$10/$16 Com	$10/$16	No	●	◒	◒	◒	●	●

** See Brochure for details on patient's payment responsibility.*

Health Maintenance Organization (HMO) and Point of Service (POS) Plans

How to read this chart: The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Guam								
PacifiCare Asia Pacific-High -Guam/N.Mariana Islands/Belau	671/647-3526	JK1	JK2	313.26	823.16	319.53	839.62	
PacifiCare Asia Pacific-Std - Guam/N.Mariana Islands/Belau	671/647-3526	JK4	JK5	246.96	652.17	251.90	665.21	
Hawaii								
HMSA - All of Hawaii	808/948-6499	871	872	292.35	650.76	298.20	663.78	NCQA 1
Kaiser Permanente-High -Islands of Hawaii/Maui/Oahu/Kauai	808/432-5955	631	632	349.09	750.53	356.07	765.54	NCQA 1
Kaiser Permanente-Std - Islands of Hawaii/Maui/Oahu/Kauai	808/432-5955	634	635	280.69	603.48	286.30	615.55	NCQA 1
Idaho								
Group Health Cooperative-High -Kootenai and Latah	888/901-4636	VR1	VR2	345.00	841.14	351.90	857.96	NCQA 1
Group Health Cooperative-Std - Kootenai and Latah	888/901-4636	VR4	VR5	298.98	687.66	304.96	701.41	NCQA 1
Illinois								
Aetna HealthFund (Consumer Driven Plan) - Chicago Area	888/238-6240	221	222	280.45	645.08	286.06	657.98	
BlueCHOICE - Madison and St. Clair counties	800/634-4395	9G1	9G2	332.97	720.92	339.63	735.34	NCQA 1
Group Health Plan - Southern/Metro East/Central	800/755-3901	MM1	MM2	427.96	924.37	436.52	942.86	URAC 1
Health Alliance HMO - Central/E.Central/N.West/South/West IL	800/851-3379	FX1	FX2	367.03	856.64	374.37	873.77	NCQA 1
Humana CoverageFirst (Consumer Driven Plan) - Chicago	888/393-6765	MW1	MW2	166.53	383.00	169.86	390.66	
Humana Health Plan Inc.-High -Chicago area	888/393-6765	751	752	337.98	777.34	344.74	792.89	
Humana Health Plan Inc.-Std - Chicago area	888/393-6765	754	755	259.13	595.96	264.31	607.88	
John Deere Health Plan - Bloomingtn/Moline/Peoria/RockIsld	800/247-9110	YH1	YH2	308.17	755.00	314.33	770.10	NCQA 1
Mercy Health Plans/Premier Health Plans - Southwest Illinois	800/327-0763	7M1	7M2	419.34	905.80	427.73	923.92	
OSF HealthPlans - Central/Central-Northwestern Illinois	800/673-5222	9F1	9F2	283.36	745.20	289.03	760.10	NCQA 1
PersonalCare's HMO - Central Illinois	800/431-1211	GE1	GE2	298.39	767.22	304.36	782.56	NCQA 1
Unicare HMO - Chicagoland Area	888/234-8855	171	172	316.98	862.68	323.32	879.93	NCQA 1
Union Health Service - Chicago area	312/829-4224	761	762	268.02	664.60	273.38	677.89	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 4 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 4 for details. A lower number means a better accreditation.

Plan Name		Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
				Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Guam												
PacifiCare Asia Pacific-High		$10/$10	None	$5	$5/$20	No	●	○	◒	◒	◒	◒
PacifiCare Asia Pacific-Std		$15/$15	$150	$5	$5/$20	No	●	○	◒	◒	◒	◒
Hawaii												
HMSA	- In-Network	$15/$15	None	$5	$20/50%	Yes	●	●	●	●	●	●
	- Out-of-Network	30% sch +/30% sch +	None	$5+20%+	$20+20%+/50%+	No						
Kaiser Permanente-High		$10/$10	None	$10	$10	Yes	●	◒	◒	◒	◒	◒
Kaiser Permanente-Std		$15/$15	None	$10	$10	Yes	●	◒	◒	◒	◒	◒
Idaho												
Group Health Cooperative-High		$15/$15	$200/day x 3	$15	$25/$50	Yes	◒	◒	●	◒	◒	◒
Group Health Cooperative-Std		$20+20%/$20+20%	$200/day x 3	$20	$30/$60	Yes	◒	◒	●	◒	◒	◒
Illinois												
Aetna HealthFund	- In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
	- Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
BlueCHOICE		$10/$10	None	$7	$12/$25	Yes	◒	●	●	◒	◒	◒
Group Health Plan		$10/$20	$100	$10	$20/$35	Yes	◒	◒	◒	◒	◒	◒
Health Alliance HMO		$15/$15	$100	$10	$20/$40	No	●	◒	●	◒	◒	●
Humana CoverageFirst	- In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
	- Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana Health Plan Inc.-High		$10/$20	$100/day x 3	$5/$15	$15/$35	No	◒	○	◒	◒	○	○
Humana Health Plan Inc.-Std		$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	○	◒	◒	○	○
John Deere Health Plan		$15/$15	$100/day x 5	$10	$20/$35	Yes	●	●	●	◒	●	●
Mercy Health Plans/Premier	- In-Network	$10/$20	None	$10	$20/$35	Yes	◒	●	◒	◒	◒	◒
	- Out-of-Network	30%/30%	None	N/A	N/A	No						
OSF HealthPlans		$20/$20	$500	$10	$20/$40	No	●	◒	●	●	◒	●
PersonalCare's HMO		$20/$20	$100/day x 5	$10	$20/$50	No	◒	●	●	◒	◒	◒
Unicare HMO		$15/$15	None	$5	$15/$25	No	◒	◒	○	◒	◒	○
Union Health Service		$10/$10	None	$15	$15/$15	No						

** See Brochure for details on patient's payment responsibility.*

Health Maintenance Organization (HMO) and Point of Service (POS) Plans

How to read this chart: The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Indiana								
Advantage Health Plan, Inc. - Most of Indiana	800/553-8933	6Y1	6Y2	366.21	859.84	373.53	877.04	NCQA 6
Aetna Health Inc. - Southeastern Indiana	800/537-9384	RD1	RD2	327.17	804.01	333.71	820.09	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - Lake and Porter Counties	888/238-6240	221	222	280.45	645.08	286.06	657.98	
Arnett HMO - Lafayette area	765/448-7440	G21	G22	277.25	720.89	282.80	735.31	NCQA 1
Health Alliance HMO - Fountain/Vermillion/Warren Counties	800/851-3379	FX1	FX2	367.03	856.64	374.37	873.77	NCQA 1
Humana CoverageFirst (Consumer Driven Plan) - Southern Indiana	888/393-6765	BM1	BM2	249.77	574.51	254.77	586.00	
Humana CoverageFirst (Consumer Driven Plan) - Lake/Porter/LaPorte Counties	888/393-6765	MW1	MW2	166.53	383.00	169.86	390.66	
Humana Health Plan - Southern Indiana	888/393-6765	D21	D22	385.82	887.32	393.54	905.07	NCQA 2
Humana Health Plan Inc.-High -Lake/Porter/LaPorte Counties	888/393-6765	751	752	337.98	777.34	344.74	792.89	
Humana Health Plan Inc.-Std - Lake/Porter/LaPorte Counties	888/393-6765	754	755	259.13	595.96	264.31	607.88	
M*Plan - Indiana Metropolitan areas	317/571-5320	IN1	IN2	407.88	936.09	416.04	954.81	NCQA 1
Physicians Health Plan of Northern Indiana - Northeast Indiana	260/432-6690	DQ1	DQ2	335.27	752.81	341.98	767.87	
Unicare HMO - Lake/Porter Counties	888/234-8855	171	172	316.98	862.68	323.32	879.93	NCQA 1
Iowa								
Avera Health Plans - Northwestern Iowa	888/322-2115	AV1	AV2	313.67	732.51	319.94	747.16	
Coventry Health Care of Iowa - Central Iowa/Cedar Rapids/Sioux City	800/257-4692	SV1	SV2	290.64	784.90	296.45	800.60	NCQA 1
Health Alliance HMO - Central and Eastern Iowa	800/851-3379	FX1	FX2	367.03	856.64	374.37	873.77	NCQA 1
John Deere Health Plan - Central/Eastern Iowa	800/247-9110	YH1	YH2	308.17	755.00	314.33	770.10	NCQA 1
Sioux Valley Health Plan-High -Northwestern Iowa	800/752-5863	AU1	AU2	462.93	1064.38	472.19	1085.67	
Sioux Valley Health Plan-Std - Northwestern Iowa	800/752-5863	AU4	AU5	392.86	903.13	400.72	921.19	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 4 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 4 for details. A lower number means a better accreditation.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Indiana											
Advantage Health Plan, Inc.	$15/$30	$400x2/Yr	$10	$30/$50	Yes	○	◒	◒	●	◒	◒
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	●	◒	◒	○
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
Arnett HMO	$10/$10	None	$10	$20/$40	No	●	●	●	◒	●	●
Health Alliance HMO	$15/$15	$100	$10	$20/$40	No	●	◒	●	◒	◒	●
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana Health Plan	$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	◒	◒	◒	◒	◒
Humana Health Plan Inc.-High	$10/$20	$100/day x 3	$5/$15	$15/$35	No	◒	○	◒	◒	○	○
Humana Health Plan Inc.-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	○	◒	◒	○	○
M*Plan	$15/$30	$250	$10/$20	$30/$50	Yes	◒	◒	◒	◒	○	◒
Physicians Health Plan of Northern Indiana	$15/$15	20%	$10	$20/$40	No	●	●	●	●	●	●
Unicare HMO	$15/$15	None	$5	$15/$25	No	◒	○	○	◒	○	○
Iowa											
Avera Health Plans	$10/$15	$100/dayx3	$10	$20	No						
Coventry Health Care of Iowa	$10/$10	None	$5	$15/$30	No	○	●	●	◒	○	○
Health Alliance HMO	$15/$15	$100	$10	$20/$40	No	●	◒	●	◒	◒	●
John Deere Health Plan	$15/$15	$100/day x 5	$10	$20/$35	Yes	●	●	●	◒	●	●
Sioux Valley Health Plan - In-Network	$20/$30	$100/day x 5	$15	$30/$50	No						
Sioux Valley Health Plan - Out-of-Network	40%/40%	40%	N/A	N/A	No						
Sioux Valley Health Plan - In-Network	$25/$25	$100/day x 5	$15	$30/$50	No						
Sioux Valley Health Plan - Out-of-Network	40%/40%	40%	N/A	N/A	No						

** See Brochure for details on patient's payment responsibility.*

Health Maintenance Organization (HMO) and Point of Service (POS) Plans

How to read this chart: The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Kansas								
Coventry Health Care of Kansas - Wichita/Salina areas	800/664-9251	7W1	7W2	326.97	833.82	333.51	850.50	
Coventry Health Care of Kansas - Kansas City - Kansas City area	800/969-3343	HA1	HA2	286.78	740.00	292.52	754.80	
Humana CoverageFirst (Consumer Driven Plan) - Kansas City	888/393-6765	PH1	PH2	166.53	383.00	169.86	390.66	
Humana Health Plan, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	369.87	850.72	377.27	867.73	URAC 1
Humana Health Plan, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	266.26	612.39	271.59	624.64	URAC 1
Preferred Plus of Kansas - S. Central Area	800/660-8114	VA1	VA2	459.92	1223.39	469.12	1247.86	JCAHO 1
Kentucky								
Humana CoverageFirst (Consumer Driven Plan) - Louisville	888/393-6765	BM1	BM2	249.77	574.51	254.77	586.00	
Humana Health Plan - Louisville area	888/393-6765	D21	D22	385.82	887.32	393.54	905.07	NCQA 2
United Healthcare of Ohio, Inc. - Northern Kentucky	800/231-2918	3U1	3U2	427.90	984.17	436.46	1003.85	NCQA 1
Louisiana								
Coventry Healthcare Louisiana - New Orleans area	800/341-6613	BJ1	BJ2	265.01	615.51	270.31	627.82	
Coventry Healthcare Louisiana - Baton Rouge area	800/341-6613	JA1	JA2	369.40	857.89	376.79	875.05	
Vantage Health Plan - Monroe/Shreveport/Alexandria Areas	888/823-1910	MV1	MV2	385.73	1002.89	393.44	1022.95	
Maryland								
Aetna Health Inc.-High -Northern/Central/Southern Maryland	800/537-9384	JN1	JN2	348.75	785.44	355.73	801.15	NCQA 1
Aetna Health Inc.-Std - Northern/Central/Southern Maryland	800/537-9384	JN4	JN5	229.13	536.19	233.71	546.91	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - All of Maryland	888/238-6240	221	222	280.45	645.08	286.06	657.98	
CareFirst BlueChoice - All of Maryland	866/520-6099	2G1	2G2	393.55	885.37	401.42	903.08	NCQA 2
Kaiser Permanente - Baltimore/Washington, DC areas	301/468-6000	E31	E32	316.29	752.81	322.62	767.87	NCQA 2
M.D. IPA - All of Maryland	800/251-0956	JP1	JP2	318.09	763.47	324.45	778.74	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 4 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 4 for details. A lower number means a better accreditation.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Kansas											
Coventry Health Care of Kansas	$15/$15	$100/day x 3	$5	$15/$45	Yes	○	◒	◒	●	○	◒
Coventry Health Care of Kansas - Kansas City	$15/$15	$100/day x 3	$10	$20/$50	Yes	○	◒	◒	●	○	◒
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana Health Plan, Inc.-High	$10/$20	$100/day x 3	$5/$20	$20/$40	No	○	◒	◒	○	◒	○
Humana Health Plan, Inc.-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	○	◒	◒	○	◒	○
Preferred Plus of Kansas	$10/$10	$50/day x 10	$5	$15	Yes						
Kentucky											
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana Health Plan	$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	◒	◒	◒	◒	◒
United Healthcare of Ohio, Inc.	$15/$15	$250	$10	$15/$30	Yes	◒	●	◒	●	◒	◒
Louisiana											
Coventry Healthcare Louisiana	$15/$15	$100/day x 3	$10	$20/$45	Yes	○	◒	◒	●	◒	◒
Coventry Healthcare Louisiana	$15/$15	$100/day x 3	$10	$20/$45	Yes	○	◒	◒	●	◒	◒
Vantage Health Plan	$15/$15	$250	$10	$20/$35	Yes						
Maryland											
Aetna Health Inc.-High	$15/$20	$150/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna Health Inc.-Std	$20/$25	$250/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
CareFirst BlueChoice	$20/$30	$100/day x 5	$10	$25/$40	Yes	○	○	○	◒	○	○
Kaiser Permanente	$10/$20	$100	$10/$20Net	$20/$40	Yes	◒	○	○	○	◒	◒
M.D. IPA	$10/$20	$100	$8	$20/$35	No	◒	◒	◒	◒	●	●

** See Brochure for details on patient's payment responsibility.*

Health Maintenance Organization (HMO) and Point of Service (POS) Plans

How to read this chart: The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Massachusetts								
Blue Chip, Coord Hlth Partners - Southeastern Massachusetts	401/459-5500	DA1	DA2	396.15	1014.37	404.07	1034.66	NCQA 1
ConnectiCare - Counties Hampden, Hampshire, Franklin	800/251-7722	TE1	TE2	330.11	864.54	336.71	881.83	NCQA 1
Fallon Community Health Plan - Central/Eastern Massachusetts	800/868-5200	JV1	JV2	387.10	940.83	394.84	959.65	NCQA 1
Michigan								
Bluecare Network of MI - Midland County Area	800/662-6667	K51	K52	343.40	961.11	350.27	980.33	NCQA 1
Bluecare Network of MI - Kalamazoo County Area	800/662-6667	KF1	KF2	431.86	1208.39	440.50	1232.56	NCQA 1
Bluecare Network of MI - Genesee County Area	800/662-6667	KN1	KN2	365.11	1020.70	372.41	1041.11	NCQA 1
Bluecare Network of MI - Kent County Area	800/662-6667	KR1	KR2	417.86	1207.09	426.22	1231.23	NCQA 1
Bluecare Network of MI - Mid Michigan	800/662-6667	LN1	LN2	453.98	1093.21	463.06	1115.07	NCQA 1
Bluecare Network of MI - Southeast MI	800/662-6667	LX1	LX2	259.03	774.80	264.21	790.30	NCQA 1
Grand Valley Health Plan - Grand Rapids area	616/949-2410	RL1	RL2	324.57	911.17	331.06	929.39	NCQA 1
Health Alliance Plan - Southeastern Michigan/Flint area	800/422-4641	521	522	291.37	772.07	297.20	787.51	NCQA 1
HealthPlus MI - Flint/Saginaw areas	800/332-9161	X51	X52	383.26	875.25	390.93	892.76	NCQA 1
M-Care - Southeastern Michigan and Flint area	800/658-8878	EG1	EG2	274.43	727.16	279.92	741.70	NCQA 1
OmniCare - Southeastern Michigan	800/477-6664	KA1	KA2	274.15	674.40	279.63	687.89	NCQA 3
Total Health Care - Greater Detroit/Flint areas	800/826-2862	N21	N22	250.66	615.79	255.67	628.11	
Minnesota								
Avera Health Plans - Southwestern Minnesota	888/322-2115	AV1	AV2	313.67	732.51	319.94	747.16	
HealthPartners Classic-High -Minneapolis/St. Paul/St.Cloud	952-883-5000	531	532	419.10	1005.81	427.48	1025.93	NCQA 1
HealthPartners Open Access-Basic - Minneapolis/St. Paul/St.Cloud	952-883-5000	534	535	355.25	852.54	362.36	869.59	NCQA 1
HealthPartners Primary Clinic Plan - Minneapolis/St. Paul/St. Cloud	952-883-5000	HQ1	HQ2	519.76	1247.39	530.16	1272.34	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 4 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 4 for details. A lower number means a better accreditation.

Member Survey Results: ● above average, ◒ average, ○ below average

Plan Name	Primary care/Specialist office copay	Hospital per stay deductible	Prescription Drugs: Generic	Prescription Drugs: Brand name/Non-formulary	Prescription Drugs: Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Massachusetts											
Blue Chip, Coord Hlth Partners - In-Network	$15/$25	$500	$7	$25/$40	Yes	○	●	●	●	◒	◒
Blue Chip, Coord Hlth Partners - Out-of-Network	30%/30%	None	$40+20%	$40+20%/$40+20%	No						
ConnectiCare	$10/$10	None	$10	$20/$35	Yes	●	●	●	●	●	●
Fallon Community Health Plan	$10/$10	$100	$5	$20/$40	Yes	◒	◒	●	◒	◒	◒
Michigan											
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Grand Valley Health Plan	$10/$10	None	$5	$5	No	●	◒	●	◒	●	●
Health Alliance Plan	$10/$10	None	$10	$20	Yes	◒	◒	○	◒	○	◒
HealthPlus MI	$10/$10	None	$10	$20	Yes	●	●	●	●	●	●
M-Care	$10/$10	None	$10	$20/$30	No	◒	◒	◒	◒	◒	◒
OmniCare	$10/$10	None	$5	$10/$25	Yes	○	○	○	○	◒	◒
Total Health Care	$10/$10	None	Nothing	Nothing	No	○	○	○	◒	◒	○
Minnesota											
Avera Health Plans	$10/$15	$100/dayx3	$10	$20	Yes						
HealthPartners Classic-High	$15/$15	$100	$12	$12/$24	No	○	◒	◒	◒	○	◒
HealthPartners Open Access-Basic	$15/$15	$100	$10	$10/$35	No	○	◒	◒	◒	○	◒
HealthPartners Primary Clinic Plan	$20/$20	$200	$12	$12/$24	No	○	◒	◒	◒	○	◒

Health Maintenance Organization (HMO) and Point of Service (POS) Plans

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Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Missouri								
BlueCHOICE - St Louis/Central/SW areas	800/634-4395	9G1	9G2	332.97	720.92	339.63	735.34	NCQA 1
Coventry Health Care of Kansas - Kansas City - Kansas City area	800-969-3343	HA1	HA2	286.78	740.00	292.52	754.80	
Group Health Plan - St. Louis area	800/755-3901	MM1	MM2	427.96	924.37	436.52	942.86	URAC 1
Humana CoverageFirst (Consumer Driven Plan) - Kansas City	888/393-6765	PH1	PH2	166.53	383.00	169.86	390.66	
Humana Health Plan, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	369.87	850.72	377.27	867.73	URAC 1
Humana Health Plan, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	266.26	612.39	271.59	624.64	URAC 1
Mercy Health Plans/Premier Health Plans - East/Central/Southwest Missouri	800/327-0763	7M1	7M2	419.34	905.80	427.73	923.92	
Montana								
New West Health Services - Most of Montana	800/290-3657	NV1	NV2	332.04	738.79	338.68	753.57	
Nevada								
Aetna Health Inc. - Las Vegas Area	800/537-9384	Y11	Y12	291.42	725.60	297.25	740.11	
Health Plan of Nevada - Las Vegas area	800/777-1840	NM1	NM2	199.25	510.14	203.24	520.34	NCQA 2
PacifiCare Desert Region (NV) - Las Vegas/Clark County	800-531-3341	K91	K92	271.05	615.27	276.47	627.58	NCQA 2
New Jersey								
Aetna Health Inc. - All of New Jersey	800/537-9384	P31	P32	344.28	830.77	351.17	847.39	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - All of New Jersey	888/238-6240	221	222	280.45	645.08	286.06	657.98	
AmeriHealth HMO - All of New Jersey	800/454-7651	FK1	FK2	327.69	782.38	334.24	798.03	NCQA 1
GHI Health Plan-High -Northern New Jersey	212/501-4444	801	802	401.20	1002.99	409.22	1023.05	URAC 1
New Mexico								
Cimarron Health Plan - All of New Mexico	800/473-0391	PX1	PX2	347.21	911.80	354.15	930.04	NCQA 2
Lovelace Health Plan - All of New Mexico	800/244-6224	Q11	Q12	333.47	818.33	340.14	834.70	NCQA 1
Presbyterian Health Plan - All NM counties except Otero & S. Eddy	800/356-2219	P21	P22	312.76	815.64	319.02	831.95	NCQA 2

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 4 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 4 for details. A lower number means a better accreditation.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs: Generic	Prescription Drugs: Brand name/ Non-formulary	Prescription Drugs: Mail order discount	Member Survey Results (● above average, ◒ average, ○ below average): Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Missouri											
BlueCHOICE	$10/$10	None	$7	$12/$25	Yes	◒	●	●	◒	◒	◒
Coventry Health Care of Kansas - Kansas City	$15/$15	$100/day x 3	$10	$20/$50	Yes	○	◒	◒	●	○	◒
Group Health Plan	$10/$20	$100	$10	$20/$35	Yes	◒	◒	◒	◒	◒	◒
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana Health Plan, Inc.-High	$10/$20	$100/day x 3	$5/$20	$20/$40	No	○	◒	◒	○	◒	○
Humana Health Plan, Inc.-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	○	◒	◒	○	◒	○
Mercy Health Plans/Premier - In-Network	$10/$20	None	$10	$20/$35	Yes	◒	●	●	●	●	●
Mercy Health Plans/Premier - Out-of-Network	30%/30%	None	N/A	N/A	No						
Montana											
New West Health Plan	$15/$15	$100	$10	$20/$40	Yes						
Nevada											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes						
Health Plan of Nevada	$10/$10	$100	$5	$20/$35	Yes	○	○	○	○	○	○
PacifiCare Desert Region (AZ & NV)	$15/$30	$200/ day x 5	$15	$35/$50	Yes	◒	○	○	○	◒	◒
New Jersey											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	◒	◒	◒	◒
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
AmeriHealth HMO	$30/$35	$200/day x 3	$15	$40/50%	Yes	○	◒	◒	◒	◒	○
GHI Health Plan - In-Network	$15/$15	None	$10	$20/$50	Yes	◒	◒	◒	◒	○	◒
GHI Health Plan - Out-of-Network	50% of sch./50% of sch.	None	N/A	N/A	No						
New Mexico											
Cimarron Health Plan	$10/$10	$100	$5	$15/$30	Yes	○	○	○	○	○	○
Lovelace Health Plan	$15/$25	$250	$7	$15/$35	Yes	◒	○	○	◒	◒	◒
Presbyterian Health Plan	$10/$10	None	$7	$17/$34	Yes	◒	○	○	◒	◒	◒

** See Brochure for details on patient's payment responsibility.*

Health Maintenance Organization (HMO) and Point of Service (POS) Plans

How to read this chart: The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
New York								
Aetna Health Inc. - NYC Area and Dutchess/Sullivan/Ulster	800/537-9384	JC1	JC2	349.92	861.36	356.92	878.59	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - New York City Area	888/238-6240	221	222	280.45	645.08	286.06	657.98	
Blue Choice - Rochester area	800/462-0108	MK1	MK2	260.20	652.21	265.40	665.25	NCQA 2
Capital District Physicians' Health Plan - North/Central New York	518/641-3700	PW1	PW2	340.02	870.03	346.82	887.43	NCQA 1
Capital District Physicians' Health Plan - Hudson Valley area	518/641-3700	QB1	QB2	329.90	845.35	336.50	862.26	NCQA 1
Capital District Physicians' Health Plan - Capital District area	518/641-3700	SG1	SG2	319.82	819.07	326.22	835.45	NCQA 1
GHI Health Plan-High -All of New York	212/501-4444	801	802	401.20	1002.99	409.22	1023.05	URAC 1
GHI Health Plan-Std - NYC/Brnx/Kings/Queen/Rich/Nass/Suff/Rock/Westche	212/501-4444	804	805	344.22	860.60	351.10	877.81	URAC 1
GHI HMO Select - Brnx/Brklyn/Manhat/Queen/Richmon/Westche	877/244-4466	6V1	6V2	381.98	949.02	389.62	968.00	NCQA 3
GHI HMO Select - Capital/Hudson Valley Regions	877/244-4466	X41	X42	357.37	917.78	364.52	936.14	NCQA 3
HIP of Greater New York-High -New York City area	800/HIP-TALK	511	512	316.53	886.23	322.86	903.95	NCQA 2
HIP of Greater New York-Std - New York City area	800/HIP-TALK	514	515	253.41	709.54	258.48	723.73	NCQA 2
HMO Blue - Utica/Rome/Central New York areas	800/722-7884	AH1	AH2	457.23	1167.57	466.37	1190.92	NCQA 1
HMOBlue-CNY - Syracuse/Binghamton/Elmira areas	800/828-2887	EB1	EB2	397.52	919.66	405.47	938.05	NCQA 1
Independent Health Assoc - Western New York	800/453-1910	QA1	QA2	227.67	637.37	232.22	650.12	NCQA 1
MVP Health Care - Eastern Region	888/687-6277	GA1	GA2	268.02	692.19	273.38	706.03	NCQA 1
MVP Health Care - Central Region	888/687-6277	M91	M92	303.94	784.81	310.02	800.51	NCQA 1
MVP Health Care - Mid-Hudson Region	888/687-6277	MX1	MX2	312.13	806.20	318.37	822.32	NCQA 1
Preferred Care - Rochester area	800/950-3224	GV1	GV2	259.05	691.62	264.23	705.45	NCQA 1
Univera Healthcare - Western New York (Southern Counties)	716/847-0881	KQ1	KQ2	313.47	830.42	319.74	847.03	NCQA 1
Univera Healthcare - Western New York (Northern Counties)	716/847-0881	Q81	Q82	247.33	701.26	252.28	715.29	NCQA 1
Vytra Health Plans - Queens/Nassau/Suffolk Counties	800/406-0806	J61	J62	380.32	997.36	387.93	1017.31	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 4 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 4 for details. A lower number means a better accreditation.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
New York											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	○	◒	○	◒	◒
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
Blue Choice	$15/$15	None	$5	$20/$35	No	●	●	●	●	◒	●
Capital District Physicians' Health Plan	$15/$15	$240	$10	$20/$35	Yes	●	●	●	●	●	●
Capital District Physicians' Health Plan	$15/$15	$240	$10	$20/$35	Yes	●	●	●	●	●	●
Capital District Physicians' Health Plan	$15/$15	$240	$10	$20/$35	Yes	●	●	●	●	●	●
GHI Health Plan - In-Network	$15/$15	None	$10	$20/$50	Yes	◒	◒	◒	◒	○	◒
GHI Health Plan - Out-of-Network	50% of sch./50% of sch.	None	N/A	N/A	No						
GHI Health Plan-Std	$25/$25	$250/day x 3	$10	$25/$50	Yes	◒	◒	◒	◒	○	◒
GHI HMO Select	$10/$10	None	$10	$20/$30	Yes	○	○	◒	◒	○	○
GHI HMO Select	$10/$10	None	$10	$20/$30	Yes	○	○	◒	◒	○	○
HIP of Greater New York-High	$10/$10	None	$10	$15/$40	Yes	◒	◒	○	○	◒	○
HIP of Greater New York-Std	$10/$20	$500	$10	$20/$40	Yes	◒	◒	○	○	◒	○
HMO Blue	$15/$15	$240	$10	$25/$40	No	◒	●	●	●	○	◒
HMOBlue-CNY	$15/$15	$100	$10	$25/$40	No	◒	●	●	●	○	◒
Independent Health Assoc	$15/$15	None	$10	$20/$35	No	◒	●	●	●	●	●
MVP Health Care	$15/$15	$240	$5	$20/$40	Yes	●	●	●	●	●	◒
MVP Health Care	$15/$15	$240	$5	$20/$40	Yes	●	●	●	●	●	◒
MVP Health Care	$15/$15	$240	$5	$20/$40	Yes	●	●	●	●	●	◒
Preferred Care	$15/$15	None	$10	$20/$35	Yes	●	●	●	●	●	●
Univera Healthcare	$15/$15	$250	$10	$20/$45	No	◒	●	●	◒	◒	●
Univera Healthcare	$15/$15	$250	$10	$20/$45	No	◒	●	●	◒	◒	●
Vytra Health Plans	$10/$10	None	$5	$10	Yes	◒	●	◒	◒	●	◒

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Health Maintenance Organization (HMO) and Point of Service (POS) Plans

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Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
North Dakota								
Heart of America HMO - Northcentral North Dakota	800-525-5661	RU1	RU2	256.58	659.40	261.71	672.59	
Ohio								
Aetna Health Inc. - Cleveland Area	800/537-9384	7D1	7D2	305.72	736.30	311.83	751.03	NCQA 1
Aetna Health Inc. - Greater Cincinnati Area	800/537-9384	RD1	RD2	327.17	804.01	333.71	820.09	NCQA 1
AultCare HMO - Stark/Carroll/Holmes/Tuscarawas/Wayne Co	330/363-6360	3A1	3A2	316.07	776.01	322.39	791.53	
Blue HMO - Most of Ohio	800/228-4375	R51	R52	376.37	934.77	383.90	953.47	NCQA 1
HMO Health Ohio - Northeast Ohio	800/522-2066	L41	L42	327.47	837.74	334.02	854.49	NCQA 1
HOMETOWN HEALTH PLAN - Massillon	800-426-9013	MZ1	MZ2	280.95	702.41	286.57	716.46	
Humana CoverageFirst (Consumer Driven Plan) - Cincinnati	888/393-6765	L81	L82	208.17	478.77	212.33	488.35	
Kaiser Permanente - Cleveland/Akron areas	800/686-7100	641	642	328.86	807.02	335.44	823.16	
Paramount Health Care - Northwest/North Central Ohio	800/462-3589	U21	U22	334.88	886.67	341.58	904.40	NCQA 1
SummaCare Health Plan - Cleveland, Akron areas	330/996-8700	5W1	5W2	315.10	866.49	321.40	883.82	NCQA 1
SuperMed HMO - Northeast Ohio	800/522-2066	5M1	5M2	364.13	931.43	371.41	950.06	NCQA 1
The Health Plan of the Upper Ohio Valley - Eastern Ohio	800/624-6961	U41	U42	334.64	769.60	341.33	784.99	NCQA 1
United Healthcare of Ohio, Inc. - Cincinnati/Dayton/Springfield areas	800/231-2918	3U1	3U2	427.90	984.17	436.46	1003.85	NCQA 1
Oklahoma								
Aetna Health Inc. - Oklahoma City/Tulsa Areas	800/537-9384	SL1	SL2	340.30	830.01	347.11	846.61	NCQA 1
PacifiCare Southwest Region (OK) - Central/Northeastern Oklahoma	800-531-3341	2N1	2N2	351.30	846.71	358.33	863.64	NCQA 1
Oregon								
Kaiser Permanente-High -Portland/Salem areas	800/813-2000	571	572	369.68	848.40	377.07	865.37	NCQA 1
Kaiser Permanente-Std - Portland/Salem areas	800/813-2000	574	575	324.29	744.23	330.78	759.11	NCQA 1
PacifiCare of Oregon - Metro Portland/Salem/Corvalis/Eugene	800-531-3341	7Z1	7Z2	362.16	814.88	369.40	831.18	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
North Dakota											
Heart of America HMO	$10/Nothing	None	50%	50%	No						
Ohio											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	●	◒	◒	○
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	●	◒	◒	○
AultCare HMO	$10/$10	None	$10	$20/$35	No	●	●	●	◒	●	●
Blue HMO	$10/$10	None	$10	$20/$30	Yes	◒	●	●	●	○	◒
HMO Health Ohio	$10/$10	None	$10	$20/$30	Yes	◒	◒	◒	◒	◒	○
HOMETOWN HEALTH PLAN	$15/$20	$250	$15	$25/$40	No						
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Kaiser Permanente	$10/$10	$100	$10	$25	No	●	◒	◒	◒	◒	◒
Paramount Health Care	$10/$20	$300	$5	$15/$25	No	●	●	◒	◒	●	●
SummaCare Health Plan	$10/$10	None	$10	$20/$40	Yes	◒	●	●	●	◒	●
SuperMed HMO	$10/$10	None	$10	$20	Yes	◒	◒	◒	◒	◒	○
The Health Plan of the Upper Ohio Valley	$10/$20	$250	$15	$30/$50	Yes	◒	●	●	●	●	●
United Healthcare of Ohio, Inc.	$15/$15	$250	$10	$15/$30	Yes	◒	●	◒	●	◒	◒
Oklahoma											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes						
PacifiCare Southwest Region (OK & TX)	$20/$40	$400/day x 5	$20	$40/$50	Yes	◒	○	◒	◒	◒	◒
Oregon											
Kaiser Permanente-High	$10/$10	None	$10	$20	Yes	◒	◒	○	○	●	◒
Kaiser Permanente-Std	$15/$15	None	$15	$30	Yes	◒	◒	○	○	●	◒
PacifiCare of Oregon	$20/$45	$400/day x 5	$20	$40/$50	Yes	◒	◒	●	●	◒	◒

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Health Maintenance Organization (HMO) and Point of Service (POS) Plans

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Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Pennsylvania								
Aetna Health Inc. - Philadelphia and Southeastern PA	800/537-9384	P31	P32	344.28	830.77	351.17	847.39	NCQA 1
Aetna Health Inc. - Pittsburgh Area	800/537-9384	YE1	YE2	268.65	740.83	274.02	755.65	
Aetna HealthFund (Consumer Driven Plan) - Philadelphia and Southeastern PA	888/238-6240	221	222	280.45	645.08	286.06	657.98	
HealthAmerica Pennsylvania-High -Greater Pittsburgh area	866/351-5946	261	262	355.83	907.38	362.95	925.53	NCQA 1
HealthAmerica Pennsylvania-Std - Greater Pittsburgh area	866/351-5946	264	265	320.52	817.31	326.93	833.66	NCQA 1
HealthAmerica Pennsylvania-High -Northeast Pennsylvania	866/351-5946	4N1	4N2	388.14	962.56	395.90	981.81	
HealthAmerica Pennsylvania-Std - Northeast Pennsylvania	866/351-5946	4N4	4N5	349.92	867.79	356.92	885.15	
HealthAmerica Pennsylvania-High -Central Pennsylvania	866/351-5946	SW1	SW2	383.93	929.87	391.61	948.47	NCQA 1
HealthAmerica Pennsylvania-Std - Central Pennsylvania	866/351-5946	SW4	SW5	344.87	835.27	351.77	851.98	NCQA 1
HealthAmerica Pennsylvania-High -Northwestern Pennsylvania	866/351-5946	VJ1	VJ2	324.00	826.24	330.48	842.76	
HealthAmerica Pennsylvania-Std - Northwestern Pennsylvania	866/351-5946	VJ4	VJ5	296.57	756.32	302.50	771.45	
Keystone Health Plan Central - Harrisburg/Northern Region/Lehigh Valley	800/622-2843	S41	S42	377.46	906.04	385.01	924.16	NCQA 1
Keystone Health Plan East - Philadelphia area	800/227-3115	ED1	ED2	348.27	918.36	355.24	936.73	NCQA 1
UPMC Health Plan - Western Pennsylvania area	888/876-2756	8W1	8W2	338.24	862.79	345.00	880.05	
Puerto Rico								
Humana Health Plans of Puerto Rico - Puerto Rico	800/314-3121	ZJ1	ZJ2	180.92	416.13	184.54	424.45	
Triple-S - All of Puerto Rico	787/749-4777	891	892	244.66	525.53	249.55	536.04	
Rhode Island								
Blue Chip, Coord Hlth Partners - All of Rhode Island	401/459-5500	DA1	DA2	396.15	1014.37	404.07	1034.66	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Pennsylvania											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	○	◒	◒	◒	◒	◒
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes						
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
HealthAmerica Pennsylvania-High	$10/$20	None	$10	$20/$40	Yes	○	●	●	●	◒	○
HealthAmerica Pennsylvania-Std	$20/$30	$200/day x 3	$10	$35/$60	Yes	○	●	●	●	◒	○
HealthAmerica Pennsylvania-High	$10/$20	None	$10	$20/$40	Yes						
HealthAmerica Pennsylvania-Std	$20/$30	$200/day x 3	$10	$35/$60	Yes						
HealthAmerica Pennsylvania-High	$10/$20	None	$10	$20/$40	Yes	○	●	●	●	◒	○
HealthAmerica Pennsylvania-Std	$20/$30	$200/day x 3	$10	$35/$60	Yes	○	●	●	●	◒	○
HealthAmerica Pennsylvania-High	$10/$20	None	$10	$20/$40	Yes						
HealthAmerica Pennsylvania-Std	$20/$30	$200/day x 3	$10	$35/$60	Yes						
Keystone Health Plan Central	$15/$20	None	$10	$25/$40	Yes	●	●	●	●	◒	●
Keystone Health Plan East	$10/$15	None	$5	$15/$25	Yes	○	◒	◒	◒	●	◒
UPMC Health Plan	$10/$10	None	$5	$15/$35	Yes	◒	●	◒	◒	◒	◒
Puerto Rico											
Humana Health Plans of Puerto Rico - In-Network	$5/$5	None	$2.50	$5	No						
Humana Health Plans of Puerto Rico - Out-of-Network	$8/$8	$50	N/A	N/A	No						
Triple-S - In-Network	$7.50/$10	None	$5	$8/$12	Yes	●	●	○	●	●	◒
Triple-S - Out-of-Network	$7.50 + 10%/$10 + 10%	None	25%	25%	No						
Rhode Island											
Blue Chip, Coord Hlth Partners - In-Network	$15/$25	$500	$7	$25/$40	Yes	○	●	●	●	◒	◒
Blue Chip, Coord Hlth Partners - Out-of-Network	30%/30%	None	$40+20%	$40+20%	No						

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Health Maintenance Organization (HMO) and Point of Service (POS) Plans

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		Self only	Self & family	Self only	Self & family	Self only	Self & family	
South Dakota								
Avera Health Plans - Eastern and Central South Dakota	888/322-2115	AV1	AV2	313.67	732.51	319.94	747.16	
Sioux Valley Health Plan-High -Eastern/Central/Rapid City Areas	800/752-5863	AU1	AU2	462.93	1064.38	472.19	1085.67	NCQA 2
Sioux Valley Health Plan-Std - Eastern/Central/Rapid City Areas	800/752-5863	AU4	AU5	392.86	903.13	400.72	921.19	NCQA 2
Tennessee								
Aetna Health Inc. - Nashville Area	800/537-9384	6J1	6J2	299.95	723.32	305.95	737.79	NCQA 1
Aetna Health Inc. - Memphis Area	800/537-9384	UB1	UB2	287.24	768.52	292.98	783.89	NCQA 1
Humana CoverageFirst (Consumer Driven Plan) - Memphis	888/393-6765	L61	L62	208.17	478.77	212.33	488.35	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

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Plan Name		Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
				Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
South Dakota												
Avera Health Plans		$10/$15	$100/dayx3	$10	$20	No						
Sioux Valley Health Plan	- In-Network	$20/$30	$100/day x 5	$15	$30/$50	No	○	◒	●	◒	◒	○
	- Out-of-Network	40%/40%	40%	N/A	N/A	No						
Sioux Valley Health Plan	- In-Network	$25/$25	$100/day x 5	$15	$30/$50	No	○	◒	●	◒	◒	○
	- Out-of-Network	40%/40%	40%	N/A	N/A	No						
Tennessee												
Aetna Health Inc.		$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	◒	◒	●	○
Aetna Health Inc.		$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	◒	◒	●	○
Humana CoverageFirst	- In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
	- Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						

** See Brochure for details on patient's payment responsibility.*

Health Maintenance Organization (HMO) and Point of Service (POS) Plans

How to read this chart: The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Texas								
Aetna Health Inc. - Austin/San Antonio Areas	800/537-9384	P11	P12	276.90	697.58	282.44	711.53	NCQA 1
Aetna Health Inc. - Dallas/Ft Worth/Houston Areas	800/537-9384	PU1	PU2	332.76	830.74	339.42	847.35	NCQA 1
FIRSTCARE - Waco area	800/884-4901	6U1	6U2	324.65	697.43	331.14	711.38	
FIRSTCARE - West Texas	800/884-4901	CK1	CK2	409.70	880.04	417.89	897.64	
HMO Blue Texas - Houston	800/833-5318	YM1	YM2	335.38	821.02	342.09	837.44	NCQA 2
Humana CoverageFirst (Consumer Driven Plan) - Houston	888/393-6765	T21	T22	249.77	574.51	254.77	586.00	
Humana CoverageFirst (Consumer Driven Plan) - Dallas/Ft. Worth	888/393-6765	T81	T82	239.40	550.57	244.19	561.58	
Humana CoverageFirst (Consumer Driven Plan) - Corpus Christi	888/393-6765	TP1	TP2	218.57	502.69	222.94	512.74	
Humana CoverageFirst (Consumer Driven Plan) - San Antonio	888/393-6765	TU1	TU2	208.17	478.77	212.33	488.35	
Humana CoverageFirst (Consumer Driven Plan) - Austin	888/393-6765	TV1	TV2	228.97	526.63	233.55	537.16	
Humana Health Plan of Texas-High -San Antonio area	888/393-6765	UR1	UR2	369.68	850.29	377.07	867.30	
Humana Health Plan of Texas-Std - San Antonio area	888/393-6765	UR4	UR5	296.83	682.74	302.77	696.39	
Mercy Health Plans/Premier Health Plans - Webb/Zapata/Duval/Jim Hogg Counties	800/617-3433	HM1	HM2	377.24	943.13	384.78	961.99	
PacifiCare Southwest Region (TX) - San Antonio/Dallas/Ft.Worth	800-531-3341	GF1	GF2	362.05	836.23	369.29	852.95	NCQA 1
Utah								
Altius Health Plans - Wasatch Front	800/377-4161	9K1	9K2	392.97	864.54	400.83	881.83	
Vermont								
MVP Health Care - All of Vermont	888/687-6277	VW1	VW2	359.91	929.46	367.11	948.05	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 4 for a description.
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Plan Name		Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
				Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Texas												
Aetna Health Inc.		$20/$25	$250/day x 3	$10	$25/$40	Yes						
Aetna Health Inc.		$20/$25	$250/day x 3	$10	$25/$40	Yes						
FIRSTCARE		$15/$25	$100	$10	$20/$40	Yes	◒	●	●	●	◒	◒
FIRSTCARE		$15/$25	$100	$10	$20/$40	Yes	◒	●	◒	●	●	●
HMO Blue Texas		$20/$20	$100/dayx4	$10	$25/$40	Yes	○	○	○	◒	○	○
Humana CoverageFirst	- In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana CoverageFirst	- In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana CoverageFirst	- In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana CoverageFirst	- In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana CoverageFirst	- In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana Health Plan of Texas-High		$10/$20	$100/day x 3	$5/$20	$20/$40	No	◒	◒	○	◒	●	◒
Humana Health Plan of Texas-Std		$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	◒	○	◒	●	◒
Mercy Health Plans/Premier	- In-Network - Out-of-Network	$10/$10 40%/40%	None None	$7 N/A	$12/$25 N/A	Yes No	●	◒	○	●	●	●
PacifiCare Southwest Region (OK & TX)		$20/$40	$400/day x 5	$20	$40/$50	Yes	◒	○	○	○	◒	○
Utah												
Altius Health Plans		$10/$15	None	$10	$20/$40	Yes	○	◒	○	○	○	○
Vermont												
MVP Health Care		$15/$15	$240	$5	$20/$40	Yes	●	●	●	●	●	◒

** See Brochure for details on patient's payment responsibility.*

Health Maintenance Organization (HMO) and Point of Service (POS) Plans

How to read this chart: The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Virginia								
Aetna Health Inc.-High -Northern/Central/Richmond, Virginia Area	800/537-9384	JN1	JN2	348.75	785.44	355.73	801.15	NCQA 1
Aetna Health Inc.-Std - Northern/Central/Richmond, Virginia Area	800/537-9384	JN4	JN5	229.13	536.19	233.71	546.91	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - Northern/Central/Richmond VA Areas	888/238-6240	221	222	280.45	645.08	286.06	657.98	
CareFirst BlueChoice - Northern Virginia	866/520-6099	2G1	2G2	393.55	885.37	401.42	903.08	NCQA 2
Kaiser Permanente - Washington, DC area	301/468-6000	E31	E32	316.29	752.81	322.62	767.87	NCQA 2
M.D. IPA - N.VA/Cntrl VA/Richmond/Tidewater/Roanoke	800/251-0956	JP1	JP2	318.09	763.47	324.45	778.74	NCQA 1
Optima Health Plan - Peninsula/Southside Hampton Roads	800/206-1060	9R1	9R2	361.29	854.92	368.52	872.02	NCQA 1
Piedmont Community Healthcare - Lynchburg area	888/674-3368	2C1	2C2	351.33	804.48	358.36	820.57	
Washington								
Aetna Health Inc. - Western/Southeast Washington	800/537-9384	8J1	8J2	257.68	655.24	262.83	668.34	
Aetna HealthFund (Consumer Driven Plan) - Seattle/Western Washington	888/238-6240	221	222	280.45	645.08	286.06	657.98	
Group Health Cooperative-High -Most of Western Washington	888/901-4636	541	542	367.29	829.14	374.64	845.72	NCQA 1
Group Health Cooperative-Std - Most of Western Washington	888/901-4636	544	545	307.47	694.14	313.62	708.02	NCQA 1
Group Health Cooperative-High -Central WA/Spokane/Pullman	888/901-4636	VR1	VR2	345.00	841.14	351.90	857.96	NCQA 1
Group Health Cooperative-Std - Central WA/Spokane/Pullman	888/901-4636	VR4	VR5	298.98	687.66	304.96	701.41	NCQA 1
Kaiser Permanente-High -Vancouver/Longview	800/813-2000	571	572	369.68	848.40	377.07	865.37	NCQA 1
Kaiser Permanente-Std - Vancouver/Longview	800/813-2000	574	575	324.29	744.23	330.78	759.11	NCQA 1
KPS Health Plans - High -All of Western Washington	800/552-7114	VT1	VT2	387.55	846.82	395.30	863.76	
KPS Health Plans - Std - All of Western Washington	800/552-7114	L11	L12	311.98	681.70	318.22	695.33	
PacifiCare of Oregon - Clark County	800-531-3341	7Z1	7Z2	362.16	814.88	369.40	831.18	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Virginia											
Aetna Health Inc.-High	$15/$20	$150/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna Health Inc.-Std	$20/$25	$250/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
CareFirst BlueChoice	$20/$30	$100/day x 5	$10	$25/$40	Yes	○	○	○	◒	○	○
Kaiser Permanente	$10/$20	$100	$10/$20Net	$20/$40	Yes	◒	○	○	○	◒	◒
M.D. IPA	$10/$20	$100	$8	$20/$35	No	◒	◒	◒	◒	●	●
Optima Health Plan	$10/$20	$250	$10	$20/$40	Yes	●	●	◒	◒	●	●
Piedmont Community Healthcare - In-Network	$25/$25	None	$15	$30	Yes						
Piedmont Community Healthcare - Out-of-Network	40%/30%	None	$15	$30	No						
Washington											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	○	◒	◒	◒	○	○
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
Group Health Cooperative-High	$15/$15	$200/day x 3	$15	$25/$50	Yes	◒	◒	●	◒	◒	◒
Group Health Cooperative-Std	$20+20%/$20+20%	$200/day x 3	$20	$30/$60	Yes	◒	◒	●	◒	◒	◒
Group Health Cooperative-High	$15/$15	$200/day x 3	$15	$25/$50	Yes	◒	◒	●	◒	◒	◒
Group Health Cooperative-Std	$20+20%/$20+20%	$200/day x 3	$20	$30/$60	Yes	◒	◒	●	◒	◒	◒
Kaiser Permanente-High	$10/$10	None	$10	$20	Yes	◒	◒	○	○	●	◒
Kaiser Permanente-Std	$15/$15	None	$15	$30	Yes	◒	◒	○	○	●	◒
KPS Health Plans - In-Network	$15/$25	None	$5	$20/50%	Yes	●	●	●	●	●	●
KPS Health Plans - Out-of-Network	$15+45%/$25+45%	None	N/A	N/A	No						
KPS Health Plans - In-Network	$15/x3 or 20%/20%	$100/day x 5	$10	$30/50%	Yes						
KPS Health Plans - Out-of-Network	$15/x3 or 45%/45%	$100/day x 5	N/A	N/A	No						
PacifiCare of Oregon	$20/$45	$400/day x 5	$20	$40/$50	Yes						

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		Self only	Self & family	Self only	Self & family	Self only	Self & family	
West Virginia								
The Health Plan of the Upper Ohio Valley - Northern/Central West Virginia	800/624-6961	U41	U42	334.64	769.60	341.33	784.99	NCQA 1
Wisconsin								
Dean Health Plan - South Central Wisconsin	800/279-1301	WD1	WD2	293.24	791.70	299.10	807.53	NCQA 1
Group Health Cooperative - South Central Wisconsin	608/251-3356	WJ1	WJ2	286.91	775.58	292.65	791.09	NCQA 1
HealthPartners Classic-High -West Central Wisconsin	952-883-5000	531	532	419.10	1005.81	427.48	1025.93	NCQA 1
HealthPartners Open Access-Basic - West Central Wisconsin	952-883-5000	534	535	355.25	852.54	362.36	869.59	NCQA 1
HealthPartners Primary Clinic Plan - West Central Wisconsin	952-883-5000	HQ1	HQ2	519.76	1247.39	530.16	1272.34	NCQA 1
Humana CoverageFirst (Consumer Driven Plan) - Milwaukee	888/393-6765	FB1	FB2	228.97	526.63	233.55	537.16	
Wyoming								
WINhealth Partners - Wyoming	307/638-7700	PV1	PV2	371.06	1001.82	378.48	1021.86	

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Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
West Virginia											
The Health Plan of the Upper Ohio Valley	$10/$20	$250	$15	$30/$50	Yes	◒	●	●	●	●	●
Wisconsin											
Dean Health Plan	$10/$10	None	$10	30%	No	●	●	●	◒	◒	●
Group Health Cooperative	$20/$20	None	$6	$12	No	◒	◒	●	◒	◒	●
HealthPartners Classic-High	$15/$15	$100	$12	$12/$24	No	●	◒	◒	◒	●	◒
HealthPartners Open Access-Basic	$15/$15	$100	$10	$10/$35	No	●	◒	◒	◒	●	◒
HealthPartners Primary Clinic Plan	$20/$20	$200	$12	$12/$24	No	●	◒	◒	◒	●	◒
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Wyoming											
WINhealth Partners	$10/$10	None	$10	$15/$40	Yes						

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